

**United States
Agency for International Development
Regional HIV/AIDS Program
for
Southern Africa
(USAID/RHAP)**

**HIV/AIDS STRATEGIC PLAN
SOUTHERN AFRICA
FY 2004-2008**

May 6, 2004

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I. LIST OF ACRONYMS AND KEY PARTICIPANTS IN STRATEGY DEVELOPMENT

| | |
|----------|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | Antenatal Care |
| ART | Anti-retroviral treatment |
| ARV | Anti-retroviral |
| BCC | Behavior Change Communication |
| BGH | Bureau of Global Health |
| BSS | Behavioral Sentinel Surveillance |
| CA | Cooperating Agency |
| CAP | Country Assistance Plan |
| CBO | Community based organization |
| CDC | U.S. Centers for Disease Control and Prevention |
| COH | Corridors of Hope |
| CSW | Commercial Sex Worker |
| EGPAF | Elizabeth Glaser Pediatric AIDS Foundation |
| FBO | Faith based organization |
| FHI | Family Health International |
| FY | Fiscal Year |
| GDA | Global Development Alliance |
| GFATM | Global Fund for AIDS, TB & Malaria |
| HCP | Health Communication Partnership |
| HHS | Health and Human Services |
| HIV | Human Immunodeficiency Virus |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome |
| HRSA | Health Resources and Service Administration |
| IQC | Indefinite Quantity Contract |
| IR | Intermediate Result |
| M & E | Monitoring & Evaluation |
| NGO | Non-governmental organization |
| OE | Operating Expenses |
| OHA | Office of HIV/AIDS, USAID/W |
| OVC | Orphans and Vulnerable Children |
| PHN | Population, Health, and Nutrition |

| | |
|----------|---|
| PLP | Population Leadership Program Fellow |
| PMP | Performance Monitoring Plan |
| PMTCT | Prevention of Mother to Child Transmission |
| PSG | Project Support Group |
| PVO | Private voluntary organization |
| RCS | Office of Regional and Country Support, Bureau of Global Health |
| RCSA | USAID Regional Center for Southern Africa |
| RHAP | Regional HIV/AIDS Program |
| RHAP/SA | Regional HIV/AIDS Program/Southern Africa |
| SADC | Southern African Development Community |
| S/GAC | Department of State, Global AIDS Coordinator's Office |
| SMME | Small, Medium, and Micro Enterprise |
| SO | Strategic Objective |
| STI | Sexually Transmitted Infection |
| TA | Technical Assistance |
| TAACS | Technical Advisor for AIDS and Child Survival |
| TB | Tuberculosis |
| UNAIDS | Joint United Nations Program on AIDS |
| UNICEF | United Nations Children's Fund |
| US | United States |
| USAID | United States Agency for International Development |
| USAID/SA | United States Agency for International Development/South Africa |
| USAID/W | United States Agency for International Development/Washington |
| USG | United States Government |
| USPSC | United States Personal Service Contractor |
| VCT | Voluntary Counseling and Testing |
| WHO | World Health Organization |

For purposes of clarity, the following designations will be used in this document to refer to the wide variety of participants in the design of this Strategy.

The **Regional Strategy Team** refers to the team comprised of technical professionals from the United States Agency for International Development (USAID) and the U.S. Centers for Disease Control and Prevention (CDC) who have facilitated the design process and drafted the Strategy document. This team is comprised of individuals

from the RHAP office in Pretoria, from the Office of HIV/AIDS (OHA) in Washington, Population, Health, and Nutrition (PHN) officers from bilateral Missions in the RHAP region, and a Program Officer from the South Africa bilateral Mission.

The **Virtual Strategy Team** consists of the broader team of technical professionals who have participated in and guided the strategy development. This includes representation from the Africa Bureau, the OHA, the Office of Regional and Country Support (RCS) and the Office of Policy and Program Coordination.

The **Regional Stakeholders** refer to the broad group of stakeholders in the region working in the HIV/AIDS arena, excluding USG partners. This includes both organizations currently being funded by USAID as well as future potential partners.

The **Regional USG Stakeholders** refer to all the USG partners participating in HIV/AIDS activities in the region. This includes all PHN officers and CDC officers from countries in the region, as well as Embassy participants from presence and non-presence countries.

II. PREFACE

With guidance and participation from USAID/Washington, and in partnership with the U.S. Centers for Disease Control and Prevention (CDC), the Regional HIV/AIDS Program Southern Africa (RHAP/SA) has prepared a new strategy to respond to the HIV/AIDS epidemic in the most infected and affected area in the world--Southern Africa. Covering 10 countries, including Emergency Plan focus countries, non presence countries and bilateral programs, RHAP/SA intends to strengthen United States government (USG) efforts to combat the impact of HIV/AIDS across the region. RHAP/SA support will improve the knowledge base of USG managers and implementing partners across the region in order to assure quality and effective programming, fill important service delivery gaps in existing programs, targeting mobile populations, border communities and underserved Basutu and Swazi, and, should sufficient resources be available, strengthen the role of regional organizations in combating the epidemic. The purpose of this document is to elucidate RHAP's strategy to achieve these results.

This strategy has been developed in a collaborative manner to assure it accurately reflects the needs and opinions of the USG constituency and presents a comprehensive understanding of the issues. The strategy design process has benefited from a variety of contacts and visits between RHAP, USAID/Washington, CDC, other USG agencies, implementing agencies and other stakeholders and donors in the region.

The strategy process has included a thorough review of available data (See References and Bibliography section in Annex VI), appraisal of evaluations done in the region (those contracted by USAID, as well as others, listed in Annex VI), site visits to current program sites, solicitation of input from USG actors in the region (through questionnaires, interviews, and targeted discussions), and--most importantly--extensive partner and stakeholder collaboration. Current, as well as potential, partners participated in the design process and the strategy presented has benefited from contributions from the following:

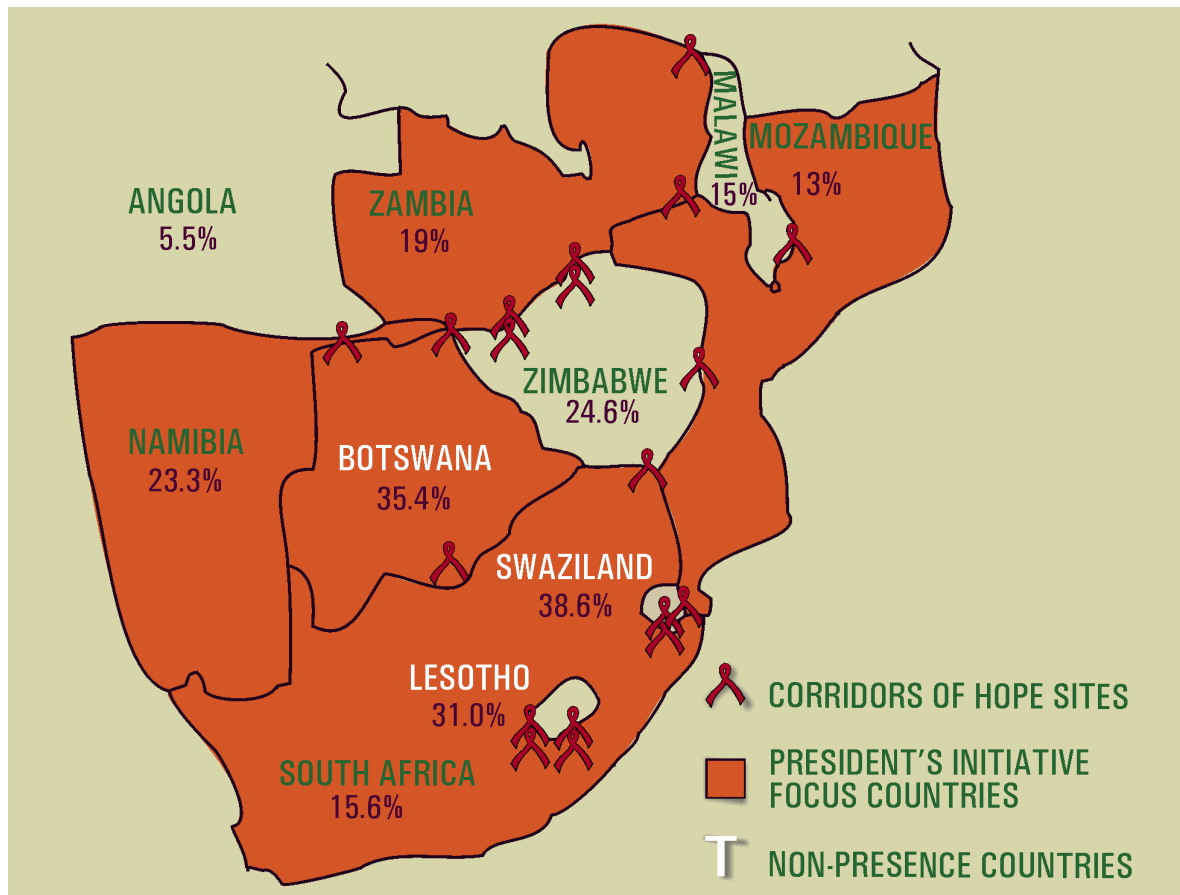
- All Bilateral Missions in the region
- Embassy partners in the three non-presence countries in the region
- All CDC officers in the region
- USAID regional programs for East, West and Southern Africa
- CDC/Southern Africa Regional Office
- USAID/Washington (Africa Bureau, OHA, RCS)
- CDC/Atlanta
- Current and potential regional and bilateral partners, including faith based organizations (FBOs)
- Regional donors

III. INTRODUCTION

In 2000, USAID launched the Regional HIV/AIDS Program for Southern Africa (RHAP), a set of regional activities intended to complement national and bilateral prevention programs. The program was initiated at the request of USAID health officers in the region who recognized: 1) the significant contribution migrant and mobile populations were making to the spread of the epidemic and 2) their lack of resources to address this population in a consistent and holistic way. Funded through the Africa Bureau, with one staff person based in USAID/SA, the primary aim of RHAP was to target high transmission populations at cross border sites primarily with prevention interventions such as behavior change education, condom social marketing, peer education, and sexually transmitted infection (STI) referral. Secondary goals of RHAP included supporting the three USAID non-presence countries in the region (Botswana, Lesotho, Swaziland), in particular through the Ambassador's Small Grants funds, and improving the capacity of all the countries in the region to respond to HIV/AIDS. Program activities have been generally successful and RHAP is positioned to expand as the USG emphasis in the region increases.

In April 2002, the USAID Administrator approved the Agency's HIV/AIDS Operational Plan, "Stepping Up the War Against AIDS". Among other directives, the plan delineated: 1) rapid scale-up countries that were to achieve measurable progress in 1-2 years; 2) intensive focus countries that were to achieve measurable progress in 3-5 years; and 3) basic countries that were to prevent a deterioration in the HIV/AIDS situation. In addition the Operational Plan articulated a strengthened role for regional programs, with primary mandates to include cross-border programs, support to non-presence countries, overall coordination and technical assistance and support to Missions. It was based on this Plan that the Agency committed to scaling up RHAP as an independent entity housed in USAID/SA and assigned a senior direct hire foreign service officer to head the program.

In June 2002, the White House further intensified the fight against the global pandemic when it introduced the Prevention of Mother to Child Transmission (PMTCT) Emergency Plan. A year later, in May 2003, the five-year \$15 billion President's Emergency Plan for AIDS Relief (the Emergency Plan) was signed by the President. This new Initiative identified focus countries worldwide to receive substantial resources and increased funding to support prevention, treatment, and care and support programs for HIV/AIDS infected and affected individuals. At the same time, the Initiative reinforced the importance of various USG agencies working together as a cohesive and collaborative unit. This has led to a new and profitable collaboration between the Southern Africa Regional CDC and USAID offices, which have engaged closely in the design of this Strategy.

MAP OF THE REGION:

Five Emergency Plan focus countries, two USAID and CDC non-presence countries and three bilateral programs are in the RHAP region. Given the magnitude of the epidemic in Southern Africa, the mandate and resources provided by USAID and broader USG leadership to address the epidemic, the demand of customer USG missions, counterparts and stakeholders and RHAP's experience and success to date, the program is well positioned to scale up its current activities and address the diverse needs of the three categories of countries in the region – Emergency Plan focus, bilateral, and non-presence.

Despite these compelling arguments in support of a strong regional HIV/AIDS program in Southern Africa, there is a great deal of uncertainty in the environment relative to USG assistance in HIV/AIDS from a regional platform. This uncertain and rapidly changing milieu poses significant constraints in articulating a strategy with a clear set of activities and results over a five-year time frame. The Emergency Plan is very new, with plans and allocations for HIV/AIDS funding closely coordinated with the State Department Global AIDS Coordinator's (S/GAC) Office. While there has been some direction provided relative to the focus countries, the implications for the regional programs and non-focus countries are as yet unclear, with a relatively grim budget outlook, at least in the near term. While the Emergency Plan strengthens the mandate for a coordinated USG response, CDC is also suffering from budget constraints relative to the regional program. In addition, as with all regional programs, there

are the issues of measuring results when many of the interventions are intended to support and facilitate broader USG efforts, and there is only a modest role in service delivery. Lastly, regional program success to some extent depends on a clear mandate for a regional role from both headquarters and the field. Even in the face of these challenges, however, there is strong consensus from most parties, supported by compelling evidence, for a regional program to address important gaps and needs. Consequently USAID has moved forward with a design based on the following principles:

- RHAP activities are demand driven. In other words, USG host country missions are the primary customers and RHAP assistance must be responsive to their stated needs.
- The complexity of the Emergency Plan, the number of partners, and the large infusion of USG resources to parts of the region requires strong communication networks and channels. RHAP stands to serve as both a link between headquarters and the field and the field and headquarters, as well as between focus and non-focus countries.
- Partnerships and leveraging are central to the success of the strategy and maximizing budget – these partnerships can be with bilateral programs, multilateral organizations, other USG partners, regional institutions and the not-for-profit and commercial sectors.
- The strategy must be flexible in order to adapt to shifting resource environments. At low levels of resources, focus countries will be asked to fund select RHAP activities, particularly those related to service delivery where achievements can be measured in terms of Emergency Plan indicators. In addition, at low levels of funding one intermediate result, related to strengthening the role of regional institutions in responding to the epidemic, will not be funded.
- While USAID guidance requires that this be a USAID strategy, RHAP shares a vision with colleagues from other USG agencies, in particular CDC. Work-planning and, where feasible, human resources will be shared among agencies in the region.

Thus, the Strategic Objective for the regional program is to strengthen the response to the HIV/AIDS epidemic in Southern Africa. This objective will be accomplished through two primary achievements:

- Increasing the use of HIV and AIDS information and services in select populations across the region, by increasing the access to and demand for services in Swaziland and Lesotho, along transport corridors, and among border and migrant communities.
- Improving the quality of USG programming by strengthening access and use of data, and facilitating communication and coordination across the region.

In addition, should a higher level of resources be available, the strategy will work to increase the participation and role of a wide variety of regional actors from the public, not for profit, and commercial sector in combating the HIV/AIDS epidemic to assure long-term sustainability. The remainder of this document will describe the situation in greater depth, present a results framework, depict illustrative activities, and articulate implementation and management plans.

IV. REGIONAL SITUATION

A. Current Status of the Epidemic

AIDS is the leading cause of death in Africa with significant demographic, health, economic, human rights, and political repercussions. At present sub-Saharan Africa has the highest HIV prevalence in the world. In sub-Saharan Africa the most affected region is the Southern Africa region, in which high population rates are combined with high prevalence rates. The result is nearly 12 million HIV positive individuals currently living in the Southern Africa region (see Annex II for all epidemiological citations).

The burden of disease due to the epidemic in the RHAP region (comprised of the 10 southernmost countries in Africa--Annex II) is staggering. Where the region is home to only 1.9% of the world's population, it accounts for 29.7% of the HIV positive individuals, 23% of the AIDS orphans, and 30.7% of the world AIDS deaths as of 2001 (UNAIDS Global Reports, 2001). As the epidemic has not peaked in any of the countries in the region, with the possible exception of Zambia, the expectation is that this disproportion will continue to worsen.

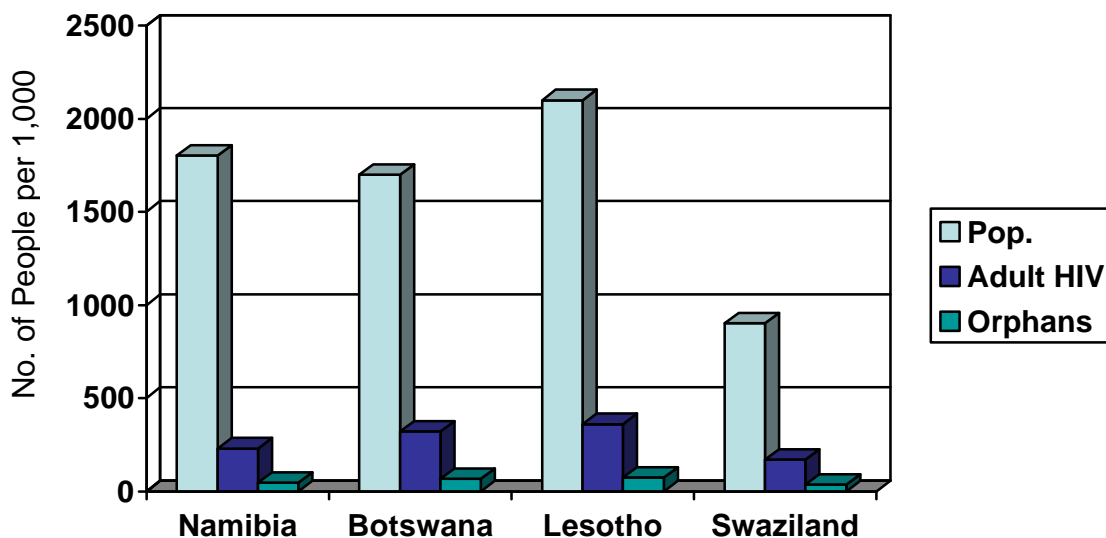
Prevalence rates in the RHAP countries vary relative to one another, but are by far the most uniformly high on the continent. Angola is the only country that reports a single digit prevalence rate at 5.5%--largely due to the immobility of the population during a prolonged civil conflict which has recently ended. The rest of the region reports double digit prevalence, from lows of 13% and 15% in Mozambique and Malawi, to highs of 31%, 35.4%, and 38.6% in Lesotho, Botswana, and Swaziland respectively. South Africa is in the mid-range with a rate of 20%, but as the majority of the inhabitants of the region are South African residents, this results in estimates of over 5 million HIV positive South Africans alone.

Most surveillance information is based on antenatal care data, and the gender inequities are reflective of some of the discrepancies in the region. Young women (15-24 years old) are at 2-3 times the risk of young men. Urban women are at more risk than non-urban women—more than double in some countries. In high risk populations, the statistics are the most alarming. Where this information has been collected, prevalence rates in the commercial sex worker (CSW) population were 3-6 times as high as in the general adult population, with rates as high as 86% in Zimbabwe in 1995. The trend is the same for urban males receiving treatment for STIs.

The behavioral data from the region is also alarming. Young age of sexual debut coupled with a high degree of transactional sex leads predictably to the prevalence rates cited above. Although there is a wide range in age of sexual debut, from 16 years old in Mozambican females, to 19.5 years old in Zimbabwean males, in general the age of first sex for girls is 1-2 years earlier than for boys, and in-school youth begin having sexual encounters earlier than out-of-school youth. There is an equally wide range of reported condom use at the last risky sex, but in general it appears that, in the highest risk age group (15-24 years), males seem to be more likely than females to have used a condom at the last risky sex. However, the most recent Behavioral Sentinel Surveillance (BSS) in Swaziland found that girls are having sex with older males, and a three-country situational analysis (Namibia, Swaziland and Lesotho) by the Health Communication Partnership (HCP) found that respondents were frequently unable to distinguish between a risky and a non-risky partner. An additional finding of the BSS is that while knowledge of HIV and prevention practices is generally good, stigma

remains a significant issue. Personal experience with the disease was generally high (up to 62% of respondents knew someone who had died as a result of AIDS, or was infected with, HIV) yet the BSS states that “attempts by families to conceal the facts are extensive”. The results from the 2002 Lesotho BSS show the same general trends, but additionally find that better knowledge is not reliably leading to changed behaviors. Of youth that knew abstinence and/or faithfulness protect them from HIV, 20-75% of women and 50-90% of men did not practice abstinence and/or faithfulness. These findings are typical of the region.

Analysis of the available data, outside of ANC surveillance, across the region reveals important gaps. Much of the data are not comparable because of different methodologies or parameters. Sometimes the most recent data that are available are from the early 1990s, and much information—especially that which records behavioral information—has simply never been collected. As epidemics know no borders, it is especially important to gather more comparable, current data in order to fully understand--and combat--the HIV/AIDS epidemic.



B. Prior assistance: Corridors of Hope Programming, 2000-2003

As mentioned above, USAID launched the Regional HIV/AIDS Program for Southern Africa (RHAP) in 2000 to address gaps identified by the USAID Population, Health and Nutrition (PHN) Officers working in the region. The intent was to deal with regional problems that could not feasibly be addressed bilaterally. In addition, many of the bilateral programs were under-resourced and regional approaches in select areas were seen as more efficient as well as a source of additional funds. The primary area of intervention for RHAP was to target high transmission populations at cross border sites with interventions such as behavior change communication (BCC), peer education, condom social marketing and STI referral. Secondary goals included supporting the three non-presence countries in the region (Botswana, Lesotho, Swaziland), and improving the capacity of all countries in the region to respond to HIV/AIDS. Program activities have been generally successful and specific achievements in program areas include:

Increased access to comprehensive HIV/AIDS services at high transmission cross border areas: The cross border initiative, known as Corridors of Hope (COH), focuses largely on condom social marketing, behavior change, and STI management. Over its first three years, RHAP gradually expanded its coverage to 32 COH sites in eight countries. In FY 2003 alone, over two million people in these sites received information about HIV/AIDS, and abstinence education and partner reduction. The central focus, however, given the primary target group of CSWs and truck drivers, was to increase knowledge of HIV and condom use. As a result the demand for male and female condoms rises each year, and over four million socially marketed condoms were distributed in FY 2003. During FY 2003, there were increased requests for expansion of the cross border program--both to accommodate more countries and to expand sites and program content, for example to include voluntary counseling and testing (VCT) in countries with existing programs.

Improved capacity of countries within the region to respond to HIV/AIDS: Emphasis has been on building capacity of local implementing partners in BCC, outreach to vulnerable women, peer education techniques, and monitoring and evaluation. Additionally, the program worked to facilitate communication in the region by hosting meetings across a wide variety of themes and partners, for example, people living with HIV/AIDS, faith-based organizations, business partnerships for HIV/AIDS, and USG partners implementing the new Emergency Plan. Broadening the understanding of difficult issues--such as violence against women, improving the quality and use of data (on behavioral surveillance, etc.), program monitoring and qualitative information to increase women's abilities to negotiate condom use--has also been a central element of RHAP.

Reduced transmission of HIV/AIDS in USAID non-presence countries (Botswana, Lesotho and Swaziland): The focus of this activity was in Lesotho and Swaziland, which have among the highest prevalence rates in the world in combination with the least amount of resources. In all three USAID non-presence countries, RHAP continued to support non-governmental and community-based organizational capacity building activities through the Ambassadors' Initiatives and small grants programs. In an effort to respond to the magnitude of the epidemic, RHAP recently increased its support to these programs. Thus, in Swaziland, RHAP is supporting implementation of the first PMTCT initiative to be implemented in the country in partnership with the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). In Lesotho, RHAP is implementing the expansion of VCT and the Health Promoting Schools initiative which engages communities, families, and students in taking responsibility for the health and well-being of the community using schools as a focal point.

In FY 2003, the Regional program began a period of rapid growth in response to the increased demand in the region, as well as to the intensified interest of the USG in addressing HIV/AIDS in southern Africa. This strategy, therefore, will speak to this scale up in the region and RHAP's emerging role in this process. Although this is a new strategy, to be implemented through a new Strategic Objective (SO), it builds on the currently successful RHAP described above.

C. Value-added Role of the Regional Program

As a consequence of renewed efforts by USAID to escalate its efforts to combat HIV/AIDS, there has been a clear mandate to strengthen regional offices with increased technical and programmatic expertise.

The 2002 USAID HIV/AIDS Operational Plan outlines the following roles for regional offices worldwide:

- Analysis of the epidemic within the region
- Technical assistance to basic and priority countries in the region (see Annex I)
- Implementation of regional programs which address the most severe sub-epidemics, the most at-risk groups, and cross border migratory populations
- Partnerships with donors in the region and assistance to countries in the region to secure funding from other sources, most notably the Global Fund for AIDS. TB and Malaria (GFATM)
- Provision of support to non-presence countries

The role of the Regional Program, however, must now be considered within the context of the Emergency Plan. All USG assistance directed to combat the epidemic is now incorporated within this plan with 15 countries targeted as focus countries. Five of those countries - South Africa, Botswana, Mozambique, Namibia and Zambia - are in the RHAP region. The Emergency Plan specifies targets in prevention, treatment, care, and support to be achieved over the next five years:

- Treat two million HIV-infected people with ARV's (approximately 50% of eligible adults and children)
- Prevent seven million new infections (60% of projected new infections)
- Provide care and support for 10 million HIV-infected individuals and AIDS orphans

Given these mandates it is necessary to determine the value-added of RHAP in terms of its contribution to these objectives. The Emergency Plan also adds another lens that the Regional Program needs to consider, the three distinct categories of countries in Southern Africa: focus countries, non-focus countries, (Angola, Malawi and Zimbabwe) and non-presence (Swaziland and Lesotho). The countries in each of these categories have distinctly different needs and present different challenges to and opportunities for RHAP. These distinctions have been carefully considered in the strategy design which seeks to: 1) implement programs that are better achieved at a regional level; 2) strengthen bilateral missions; and 3) fill any existing strategic gaps.

Given these considerations, certain areas of support and important target populations stand out. The region continues to be defined by its porous borders and the role of mobile populations with high risk behaviors in spreading the epidemic, the original target group for RHAP. The past several years of implementation have revealed additional refinements to better address the needs of high risk groups. There are three specific and distinct populations that cross-border work reaches: mobile populations (truck drivers, sex workers, traders); migrant populations (farm workers, miners, domestics workers, economic refugees); and people living in the border communities, including sex workers. While some interventions

will be similar across these populations, others will be more specifically targeted. The current Corridors of Hope focuses on populations within border towns. Analysis indicates that, while the program is reaching large numbers of people with a variety of behavior change interventions and appears to have an impact on stigma, better targeting of interventions within these groups is required to achieve the level of behavior change necessary to better prevent new infections. For example, it has become increasingly clear that truck drivers and sex workers need interventions that are coordinated and consistent along *entire* corridors as opposed to just at border crossings. Corridors of Hope builds on its high risk programs to reach border communities through resource centers, peer education targeted towards youth and home-based care. While not necessarily mobile, these communities are highly infected and affected by the epidemic, although there is some thought that they may be better served through bilateral programs. An important question for the future, concerns how mobile populations will be able to access treatment programs. An analysis of available information and feedback from stakeholders clearly support the comparative advantage of RHAP in reaching these populations and the contribution of targeted interventions to the achievement of USG goals, particularly in the area of prevention.

Another critical priority of the regional program is assistance to the non-presence countries of Swaziland and Lesotho. These countries have among the highest prevalence rates in the world, lack capacity and infrastructure to respond, and, in the case of Lesotho (which has a population larger than either Namibia or Botswana) are among the poorest countries in the world. The fact that they are non-presence countries has both limited the amount of USG funding available and the number of organizations that are operational. Among the many needs of the non-presence countries, one of the greatest gaps is in the area of service delivery. Virtually the entire spectrum of Initiative targeted services, including VCT, treatment, prevention, care and OVC programs desperately require support. Interventions in any one of these areas will contribute to Emergency Plan objectives.

In addition it is essential to note that in order for programs in the region to be successful, interventions must address gender issues. Prevention, care and treatment programs require both a need to achieve greater involvement and responsibility on the part of men as well as creating an environment where women are empowered to refuse sex and negotiate condom use. Considering gender issues will also contribute to the reduction of stigma and support an environment where disclosure of HIV status is safe and becomes the norm.

As large amounts of USG funding move into Southern Africa, two additional key issues emerge with relevance to a regional platform. One is the ability of USAID bilateral missions in both focus and non-focus countries to manage such large funding levels in terms of contracting, oversight of implementation and reporting. Support for these administrative functions as well as technical assistance in select areas such as monitoring and evaluation, treatment and human resource development were all identified as priorities for the regional program by both CDC and USAID bilateral programs. These findings have been confirmed in recent focus country meetings with headquarters. Indeed, several focus countries have indicated a willingness to fund these services from a regional platform.

There is also the critical issue of sustainability and capacity building. In order to assure program continuity into the future, strengthening local capacity and institutions is essential.

Southern Africa has the added advantage of being home to strong regional institutions which are well positioned to play a greatly increased role. These include professional associations, training institutions, media platforms, youth-serving organizations, faith-based networks and palliative care associations to name but a few. There is a vibrant region-wide corporate sector, in some cases with strong ties to multinational corporations, which increasingly is recognizing the impact that HIV/AIDS is having on societies. Equally important are the institutions which facilitate appropriate policies across the region, such as Southern African Development Community (SADC), the World Health Organization (WHO) and UNAIDS. These organizations have been partners for both CDC and USAID on the regional level and have an increasingly important role to play as countries begin to deal with the highly complex issues related to region-wide availability of treatment. Given the nature of these institutions, it is logical that support and interface would come from a regional platform. There are also important opportunities in the region to develop and strengthen linkages with other sectors to integrate HIV prevention, care, treatment and mitigation activities. In the past, RHAP and the Regional Center for Southern Africa (RCSA) based in Gaborone, Botswana have coordinated efforts for providing technical assistance to USAID missions in the Southern African region. RCSA covers 12 of the 14 SADC countries and covers an area that overlaps with all of the RHAP countries. RCSA's mandate is to address HIV/AIDS as a cross-cutting issue through other sectors. RHAP's role is to look at HIV/AIDS as it is related to health. There are several important intersections as, for example, both programs are extremely concerned about the region's unfolding food security crisis and its relation to the HIV/AIDS crisis as well as the impact of HIV/AIDS on human capacity development and manpower shortages in the region. In an effort to provide state-of-the-art technical assistance to multi-sectoral HIV/AIDS programs, RHAP will maintain ongoing and regular communication with RCSA and will facilitate collaborative planning and learning exchanges.

Among USAID implementing partners, support for these kinds of leveraging and institutional mobilization interventions were deemed the highest priority for the program. It was also recognized, however, that these programs can be costly and that it can be difficult to measure results, particularly in terms of service statistics.

Also contributing to capacity building is the need to build and disseminate a quality information base to assure learning and strong programming across the region. There is a sense of a growing gap between the Emergency Plan focus countries in the region and those which are not, in spite of the fact that some of the non-focus countries may be dealing with an HIV/AIDS problem of equal or greater magnitude. There is a need for programs to understand and use standardized, regionally comparable data (epidemiological, monitoring, evaluation, surveillance, etc.) for programming and a need to strengthen communication across the region as a whole. The regional office has a comparative advantage in supporting information exchange, dissemination of lessons learned, inter- and cross-agency collaboration, and related facets of communication. This proactive pursuit of improved communication should go far to limit the "gap" between the focus and non-focus countries and maximize resources to contribute to a more rapid and coordinated scale-up regionally. In addition a rich exchange of information will strengthen programs and capacity of local partners.

D. Regional Capacity to Respond

The U.S. Government is one of several actors focusing on the Southern Africa region as one of the “hotspots” in the HIV/AIDS pandemic. On July 4, 2003 the Heads of State or Government from SADC met in Maseru to endorse the SADC HIV/AIDS Strategic Framework and Programme of Action, 2003-2007 and to sign the SADC Maseru Declaration. These documents identify the following priority areas “requiring urgent attention and action”:

- Prevention and Social Mobilization
- Improving Care, Access to Counseling and Testing Services, Treatment and Support
- Accelerating Development and Mitigating the impact of HIV/AIDS
- Intensifying Resource Mobilization
- Strengthening Institutional, Monitoring and Evaluation Mechanisms

SADC countries include Angola, Botswana, Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe.

Of the \$2.7 billion the GFATM has awarded in its first three rounds, 60% (\$1.2 billion) has gone to HIV/AIDS. Sixty percent of the awards are targeted to sub-Saharan Africa. With this money GFATM wishes to attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigation the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need and contributing to poverty reduction as part of the Millennium Development Goals. Bilateral Missions support the country coordination teams in applying for these funds, and RHAP will support the non-presence countries in the same manner.

There are a range of other major donors in the region with a variety of areas of interest. The table in Annex IV provides a detailed break down of their areas of assistance.

The Regional office, together with CDC, will collaborate with UNAIDS and WHO to promote communication and collaboration in all areas of HIV/AIDS prevention, treatment and care and support. Special attention will be given to important regional areas such as surveillance, public-private partnerships, methodologies for HIV prevalence and behavior surveys, and monitoring and evaluation.

E. Opportunities and Threats

There are a variety of factors that are outside the manageable interests of USAID/RHAP. The interplay and outcome of these factors can have considerable impact on RHAP programming and contribute to the success or failure of the strategy. Some of the more prominent factors are listed below:

Opportunities:

External:

- Significant increase of resources: Along with the USG, many other donors are focusing attention and resources on the Southern African region. This should enable efforts on a much bigger scale and should assist in building the underlying infrastructure that has been lacking for so long.
- Increasingly widespread availability of treatment: As access to anti retroviral treatment (ART) increases, benefits will be felt in many other areas. The ability to receive treatment will reduce stigma, play a role in prevention, decrease the number of orphans, provide hope, and—most importantly—save lives and protect livelihoods. How mobile populations will access treatment, however, remains a key concern for the Regional Program.
- Improved policy environment: The recent change in policy in South Africa relative to treatment and the growing leadership across the Region to confront the epidemic have created a favorable environment for the roll-out of interventions to address the epidemic.
- Intensified integration of HIV activities into other sectors: The ability to collaborate with other sectors operating on a regional basis provides an opportunity to leverage other sectors to address key issues, for example prevention, stigma and treatment literacy. The linkage between these health integration issues with the non-health multi-sectoral approach being undertaken at Regional Center for Southern Africa (RCSA), which focuses on the impact of the epidemic on other sectors, provides opportunities to address some of the root drivers and consequence of the epidemic from a wider perspective.
- Recent peace in Angola: The only country in the region with single-digit prevalence rates is Angola, in part due to the protracted civil war which isolated it and prevented movement along the usual transmission routes. It is therefore in the unique position of being able to see into the future by observing the state of the epidemic in neighboring countries. They not only have the opportunity to begin to mobilize aid and other resources, but have the opportunity to avoid the fate of their neighbors by implementing strong prevention programs along those same newly opened routes.

Internal:

- The new mandate under the Emergency Plan for a coordinated USG approach: This plan offers a new opportunity to build on the strengths of CDC and USAID, as well as other partners such as Department of Defense, Peace Corps, and, potentially Health Resources and Services Administration (HRSA). There are multiple technical advantages as well as resource efficiencies to this approach.
- Strong Bilateral Mission programming: The ability of all Bilateral Missions in the region to focus on key initiatives in HIV/AIDS and support the Emergency Plan goals—whether they are focus countries or not—will have a big influence on the impact that HIV/AIDS has in the region. Continued and strong support for the COH programs, along with creativity to find alternate funding and management mechanisms, will do much to contribute to the success of this important facet of the Regional program.

Threats:

External:

- Insufficient human resources and attrition of professionals: The region continues to lose professionals to the “brain drain”. Now, in addition, it is losing its core

members—particularly in the health and education sectors—as they are dying of HIV/AIDS in ever increasing numbers. The impact that this has on the generation not yet lost to HIV/AIDS will continue to grow. This steady attrition is felt among USAID governmental counterparts, implementing partners, and colleagues in the workplace. The region is fighting an ever increasing battle, with an ever diminishing army.

- Political instability: The current political situation in Zimbabwe is leading to an economic crisis that is already affecting the wider region. The fact that Zimbabwe has traditionally been a major exporter of food in the region exacerbates the situation. The implications for movement, trade, and economic, political, and social repercussions in the region are undeniable.
- Regional and sub-regional Food insecurity: As Alex De Waal eloquently describes in *'New-Variant' Famine: How AIDS has changed the Hunger Equation*, the interrelation between food shortages and AIDS in Africa is only beginning to be appreciated. Due to the coping strategies developed over millennia, past societies survived drought and food scarcity. AIDS has changed this equation, in that it attacks exactly those who enabled society to resist famine. Family networks and the ability to make a living disappears, and young women are forced into “survival sex” to feed their children, brothers and sisters, and sick family members—which in turn fuels the epidemic that has led to the situation in the first place. Malnutrition then accelerates the progression to AIDS and intensifies the downward spiral.
- Upward fluctuation in the value of the South African Rand relative to the US dollar: The current economic situation in South Africa has caused all the countries in the region whose currencies are closely linked to the Rand to lose up to a third of their previous purchasing power. This has been particularly significant in relation to large grants, such as those from the GFATM. In the future, however, it will also mean that the impact of US funding flows to focus countries will not be as large as anticipated and non-focus countries, which have no increases, are actually working at effectively reduced funding levels.

Internal:

- Disparities in access to resources: The growing disparities between focus and non-focus countries and between presence and non-presence countries have been mentioned repeatedly in this document. Failure to confront this disparity and identify means to address a regional problem in a consistent and equitable way will present a major threat to the success of this strategy.
- Funding levels for the Regional program: Three scenarios are presented in this strategy, however, at the low end, only two of the three intermediate results will be achieved and results will be modest.
- Mandate for the Regional program. Given the new policies and management related to the Emergency Plan, the Regional Program can only be effective if it has approval and support for its mandate from both headquarters and the field. Support from S/GAC will be essential.

The Regional team will have to remain flexible and adaptive to respond to the threats and opportunities that eventually play out, and to refine the program to make the most of the opportunities and mitigate the threats that arise.

V. HIV/AIDS REGIONAL STRATEGY FOR 2004-2006

A. Rationale for the Regional Strategy

The magnitude of the epidemic in southern Africa, the role of high risk mobile and migrant populations in its spread, the potential capacity of regional institutions and the significant commitment of the USG to addressing the epidemic all provide compelling evidence for a USG regional program in Southern Africa. This need is equally recognized by regional partners, other donor institutions, USG country partners, and USAID and CDC headquarters. Indeed, while the intent is to have a USG strategy for HIV/AIDS in southern Africa, given the different operating policies, each agency is required to submit an independent document for headquarters' approval. The CDC Southern Africa Regional Office has submitted its Country Assistance Plan (CAP) to CDC/Atlanta based on assessment and stakeholder input that were jointly undertaken. The goals outlined in that CAP are to:

- Facilitate communication and program coordination
- Facilitate administrative and contracting support
- Provide selected program support to countries without a CDC presence
- Facilitate appropriate involvement with Regional Organizations and monitor and manage Regional Cooperative Agreements

The USAID strategy dovetails closely with this approach with the intent to address the issues in a coordinated and cohesive manner.

The strategy has been designed based on the following core principles:

- RHAP activities are demand driven. USG host country missions are primary customers and programs and assistance must be responsive to their stated needs.
- The complexity of the Emergency Plan, the number of partners, and the large infusion of USG resources to parts of the region require strong communication networks and channels. RHAP stands to serve as both a link between headquarters and the field and the field and headquarters, as well as between focus and non-focus countries.
- The strategy must be flexible in order to adapt to shifting resource environments. Focus countries will be asked to fund select RHAP activities, particularly those related to service delivery where achievements can be measured in terms of Emergency Plan indicators. In addition, at low levels of funding one intermediate result, related to strengthening the role of regional institutions in responding to the epidemic, will not be funded.
- Partnership and leveraging are central to the success of the strategy and maximizing budget – these partnerships can be with bilateral programs, multilateral organizations, other USG partners, regional institutions and the not-for-profit and commercial sectors.
- While the dictates of Agency bureaucracy require that this be a USAID strategy, RHAP shares a vision with colleagues from other USG Agencies working in the sector, in particular CDC. Work-planning and, where feasible, human resources will be shared as USG agencies work as one team to address the region.

In addition it is important to note that the Emergency Plan has dramatically changed the face of USG assistance to the sector, with a new structure of oversight and finance allocation through S/GAC. At the time of this writing, the role of the regional program relative to the Emergency Plan remains undefined, but there is wide recognition of the potential contribution RHAP could play. This strategy is designed with considerable flexibility and will be able to expand or contract depending on funding levels and shifting mandates.

B. RESULTS FRAMEWORK

S.O. STRENGTHENED RESPONSE TO HIV/AIDS IN SOUTHERN AFRICA

Illustrative Indicators

- *Number of people receiving counseling & testing for HIV/AIDS*
- *Proportion of men reporting sex with a sex worker in the last 12 months*
- *Client countries satisfied with RHAP assistance*

IR 1: Increased access to select HIV/AIDS services in target populations across the region

Illustrative Indicators:

- *Number of facilities/programs providing community outreach HIV risk avoidance/reduction services*
- *Number of persons trained to provide community outreach HIV risk avoidance/reduction services*
- *Number of facilities providing counseling and testing*
- *Number of persons trained in counseling and testing*

IR 2: Improved quality of Mission programs to combat the HIV/AIDS epidemic in the region

Illustrative Indicators:

- *Number of technical assistance/mission support visits*
- *Data available for all RHAP countries, analyzed from a regional perspective and disseminated for use in policy dialogue and programming*
- *Number of state of the art approaches disseminated*

* *Results achieved in partnership with CDC*

IR 3: Increased participation of regional networks and institutions in combating the HIV/AIDS epidemic

Illustrative Indicators:

- *Number of policies adopted by partner organizations*
- *Number of institutions in the region supported by RHAP undertaking HIV/AIDS activities in at least two countries*
- *Number of regional commercial enterprises supported by RHAP undertaking HIV/AIDS activities in at least two countries*

* *Results achieved in partnership with CDC*

C. Development Hypothesis and Target Populations

President George W. Bush has declared the fight against AIDS as one of the USG's highest priorities. The RHAP strategy is based on the recognition that although a regional program has limited resources (in many cases considerably less than the customer bilateral programs) it is well positioned to make an important contribution to the performance of USG programs and investments in HIV/AIDS across the region, enhancing results achievements overall. This facilitation role, while difficult to measure, particularly in terms of traditional health sector service delivery outcomes, is central. Specialized technical assistance (TA) will help assure that USAID Missions in the region can move efficiently to advance program funding flows, implementation and other documentation and reporting requirements. This strengthens bilateral programs. Expert TA will also strengthen technical inputs for both bilateral and host country partners, contributing to stronger program performance. Equally important, RHAP also has the advantage of a broad region-wide perspective on issues, progress, barriers and gaps. This wide lens offers multiple opportunities to leverage the resources and participation of other organizations covering the range of donors, GFATM, and local and regional partners. This contributes to efficient use of resources, capacity building and long-term sustainability. In addition the wide lens helps address important issues that affect bilateral programs but are outside their manageable interest. A current example includes how, as the South African government rolls out treatment, it will be forced to deal with the inevitable outflow of individuals particularly from Zimbabwe and Lesotho who also need ART.

In areas either under-served or unserved by bilateral programs, the USG also has a strong interest in addressing the epidemic. Swaziland and Lesotho are small islands of extremely high prevalence populations with virtually no resources in the middle of a sea of countries benefiting from the Emergency Plan. Indeed, imagining an environment where transmission continues unchecked and unstructured treatment programs contribute to ARV resistance, it is apparent that if the USG does not address the epidemic in these countries the results of the Emergency Plan itself could be jeopardized. The same is true of cross-border and highly mobile populations that are often beyond the reach of a bilateral program. Thus in these instances, RHAP support to service delivery programs will contribute to USG objectives in combating the epidemic in Southern Africa.

Given these multiple roles the target population of the program is equally diverse. It includes USG missions and staff, be it through USAID, CDC, the Embassy, Peace Corps or others. Implementing partners of all of these Agencies will also benefit from the rich information exchange that will improve programs. Should sufficient resources be available, Southern African institutions will also benefit as they increase their participation in a variety of areas in the war against AIDS. Ultimate beneficiaries of this program, however, are the people of Southern Africa who are infected and affected by this epidemic--be it directly attributable to RHAP or through bilateral partners.

D. Strategic Objectives and Results Framework

The strategic objective of the new Joint USAID/CDC HIV/AIDS regional strategy is to strengthen the response to HIV/AIDS in Southern Africa. This SO statement highlights

the priorities the USG has placed on addressing the epidemic in the region through increased resources and the need for all USG agencies and partners to mobilize efforts and scale up response. The strategic objective also reflects the inherent nature of a regional program to assist and support bilateral Missions, facilitate bilateral programming and fill needs that cannot be met through traditional bilateral approaches. Lastly the SO statement provides a role for the Regional program to serve as a voice for the USG with other donor agencies and policy groups that are looking at needs and programs from a broad region-wide perspective.

Achievement of this objective will address both the requirements of the Emergency Plan and the mandates for Regional offices specified by USAID/Washington and CDC/Atlanta, as well as complement the HIV/AIDS responses of the bilateral programs in the region. The Regional offices will play a key role in providing assistance and support to bilateral missions, communicating lessons learned and best practices, improving the quality and use of data to analyze the epidemic and develop program monitoring systems, providing services for groups not otherwise served by USAID programs, and, should sufficient funding be available, expanding networks and partnerships in the region.

Key indicators of success at the SO level include:

- Number of people receiving counseling & testing for HIV/AIDS
- Proportion of men reporting sex with a sex worker in the last 12 months
- Client countries satisfied with RHAP assistance

To achieve this objective, three intermediate results will be achieved:

IR 1: Increased access to select HIV/AIDS services in target populations across the region

IR 2: Improved quality of Mission programs to combat the HIV/AIDS epidemic in the region

IR 3: Increased participation of regional networks and institutions in combating the HIV/AIDS epidemic

The following section describes the overall purpose and some illustrative activities and indicators for each of the Intermediate Results (IRs). Certain program areas where there will be close collaboration with CDC are noted. Others, the cross-border activities in particular, will be primarily funded and implemented by USAID. After the strategy is approved, a comprehensive Performance Monitoring Plan (PMP) will be completed finalizing indicators and targets at the IR level. It is important to note that the funding scenario is very uncertain and three funding levels are described later in the document. At the low funding levels only IR 1 and 2 will be undertaken. The SO statement and indicators will be achieved at all funding levels; the magnitude of those accomplishments, however, will be dependent on the funding available.

E. Intermediate Results and Activities

IR 1: INCREASED ACCESS TO SELECT HIV/AIDS SERVICES IN TARGET POPULATIONS ACROSS THE REGION

RHAP will work to achieve this result, building on the existing programs efforts to increase access to service through Corridors of Hope and in Swaziland and Lesotho. As highlighted in the development hypothesis, it is essential to address key gaps in populations served through USG assistance in the region in order to broaden the USG response and protect investments. Given the extremely dire situation in Swaziland and Lesotho, the strategy will increase the focus on improving access to services. Activities reaching high risk mobile populations and border groups will be more targeted to better address the needs and practices of these groups who are not covered through bilateral programs. All assistance will be closely coordinated with bilateral partners, and, where possible with other sectors, in particular education and food security. Activities will specifically:

- ***Increase access to select HIV/AIDS services in Lesotho and Swaziland***

As the epidemics in Lesotho and Swaziland are generalized, interventions in these two countries will include the range of prevention, treatment, care and support activities that are necessary to accomplish the goals outlined in the Emergency Plan. The primary limiting factor will be funding levels. Specific interventions will include expanding existing programs which include prevention activities in both countries such as the promotion of abstinence and fidelity to youth and condom support to high risk populations, prevention of mother to child transmission programs in Swaziland and VCT programs in Lesotho. Community mobilization is and will continue to be central to programs. At higher funding levels, however, the scope can be expanded to include more work with HIV orphans, home-based care programs, stigma reduction and treatment literacy. A priority for additional funding would also include support to strengthen government capacity to manage HIV programs, including GFATM resources. Should funding be available the program will also consider supporting treatment efforts. Both CDC and USAID will support activities in Swaziland and Lesotho.

- ***Promote behavior change in high-risk mobile populations along transport corridors across the region***

RHAP has substantial experience in working with high risk mobile populations through peer education, counseling, condom promotion and STI treatment and referral. Activities to date, however, have focused on border sites while the evidence suggests that many high risk truck drivers and sex workers may be more active elsewhere along the transport corridor. Under this strategy, while the constellation of activities will remain similar, with the addition of VCT where feasible, the Corridors of Hope program will be adjusted to work along corridors as well as at border sites. In addition these groups need access to treatment, but their mobility places them at a distinct disadvantage when it comes to accessing services. Should sufficient resources be

available, RHAP will also investigate ways of addressing this issue. CDC does not anticipate contributing to this activity.

- ***Increase access to select HIV/AIDS services in migrant populations and border communities***

Experience has shown that the needs of migrant and border community populations are distinct from the needs of other high-risk groups along transport corridors. Programs must be developed to respond to their unique needs. Formative research is needed to better understand the behaviors and needs of migrant populations in order to design effective interventions. Border communities tend to have higher prevalence rates than the national average (50% in Francistown, 59% in Beitbridge, 42% in Victoria Falls) thus they have a significant need for holistic interventions that include the range of HIV/AIDS services. RHAP has worked with these communities in the past, particularly in the area of prevention and strengthening community responses. Under this strategy, financial constraints may limit RHAP's interventions, particularly in focus countries which should have the resources to address these populations through bilateral programs. Nonetheless, their needs remain high in other constrained programs like Zimbabwe, Malawi and the non-presence countries. CDC does not anticipate participating in this activity. This activity will only be undertaken at the high funding level scenario.

Illustrative indicators:

- Number of facilities/programs providing community outreach HIV risk avoidance/reduction services
- Number of persons trained to provide community outreach HIV risk avoidance/reduction services
- Number of facilities providing counseling and testing
- Number of persons trained in counseling and testing

IR 2: IMPROVED QUALITY OF MISSION PROGRAMS TO COMBAT THE HIV/AIDS EPIDEMIC IN THE REGION

The new Emergency Plan has shown the resolve of the USG to combat the HIV/AIDS epidemic and to contribute significant USG resources to the process. Equally, the Emergency Plan emphasizes the importance of synchronization, collaboration, and teamwork among all USG actors in their planning and programming. This implies, in many cases, developing a new way of working and building new relationships—both within the Agency as well as between USG agencies. There is a dramatically increased workload for focus country programs, often without concomitant increases in human resource levels. In addition there is an important need, both among USG staff as well as implementing and host country partners, to exchange information, learn from each other and apply that knowledge to assure that programming is of the highest quality to achieve the maximum results. This information is equally important for the focus countries with their large resource levels as well as the non-focus and non-presence countries. The

Regional office intends to take a leadership role in this process by providing resources for expert TA, improved data and strengthened program information to assist USG colleagues and their implementing partners in responding to the epidemic.

Key illustrative activities that RHAP will undertake to achieve this include:

- ***Provision of select program support and technical assistance***

Among USAID, CDC and Embassy staff there is a loud call for support and assistance from the regional program in the area of technical assistance. This assistance falls into two general categories – support to carry out routine functions, such as writing scopes of work, serving on review panels, preparing annual reports, etc, and more specialized technical assistance in specific areas such as monitoring and evaluation. While for focus countries it is the current assumption that this will be provided by Washington and Atlanta, it is unclear how feasible this will be in the long run, and there are already requests on the table for the Regional Program to serve as a platform for this assistance. There are equally important needs in non-focus and non-presence countries. Using RHAP for support of this nature provides an “economy of scale”, particularly given the limited pool of individuals in specific, highly technical areas such as ART, which makes supplying these services from a regional platform more feasible. This is an area where both USAID and CDC will contribute and, depending on the profiles of staff across agencies, in some instances actually co-fund positions. It is also worth noting that because of the need to have a small but effective team technical experts will also be expected to help countries as needed on documentation related tasks. This is in keeping with current standard practice for USAID.

- ***Support to improve the quality and use of surveillance and monitoring and evaluation data across the region***

Accurate, well-analyzed, and usable data and information, which is reasonably consistent and comparable across the region, are central to the ability to make sound program decisions. This applies to both epidemiological and behavioral surveillance, as well as to information used for monitoring and evaluating programs. The Regional office will need to assume direct responsibility for data in non-presence countries, whereas for bilateral programs, country level information will be gathered locally. Given the nature of the epidemic in Southern Africa, there is also a need for region wide analysis in order to understand the bigger picture and its implications for programming on a larger scale. It will be the role of the Regional program to augment country level data with assessment and analysis of regional trends and gaps. Because of CDC’s comparative advantage in this area, USAID will look to its technical leadership with a primary contribution through funding.

- ***Promote information exchange about effective program implementation practices***

In addition to surveillance, monitoring and evaluation there is a critical need to examine and disseminate effective programming practices across the region to

promote the state of the art in all priority areas of the Emergency Plan. Cross regional exchanges for implementing and host country partners will be essential to benefit from the various country experiences and contribute to local capacity building and long-term sustainability. The potential is significant, building on state of the art practices developed through USG and others to improve the quality and, concomitantly, the effectiveness, of programs. For example, Botswana has the longest history with counseling, testing and treatment programs, Namibia has promising HIV orphan programs, South Africa is a leader in engaging the private sector and Zambia has demonstrated the importance of community based approaches. **To specifically benefit non-presence countries, cross regional exchanges will be utilized to share successful prevention models from countries like Uganda and Zambia that prioritized behavior change through involving FBOs and other community-level groups and that advocated for fundamental changes in norms surrounding sexual behavior.** In addition there is also the need to share protocols, training curricula etc. Funding will support information dissemination through meetings, study tours and other forms of exchange. Through this process, should funding be available, important knowledge gaps will also be identified and will facilitate priority setting for operations research. Key areas for discussion and development might include food security and HIV/AIDS and the effect that HIV/AIDS is having on human capacity, including manpower shortages. Both USAID and CDC will contribute to activities in this area, and, where feasible, include other USG partners like NIH, Peace Corps and the Department of Defense.

- ***Promote improved communication across government agencies, between focus and non-focus countries, other donors and regional policy institutions***

The Emergency Plan has highlighted the need for improved communication between focus and non-focus countries and across USG agencies. In addition these efforts need to be coordinated with other donor efforts across the region, for example the WHO 3x5 Initiative and GFATM programs. As the number of actors increases, it is important to develop strong structures and practices to systematize the sharing and utilization of information to assure efficiencies and reduce duplication. Although this is also the role of S/GAC, particularly relative to the focus countries, RHAP is ideally situated to assure this communication also takes place with partners who are somewhat more removed, but equally important given the need to coordinate efforts. Thus RHAP will participate in S/GAC teams for focus countries, produce a newsletter intended primarily for USG partners on activities across the region and host fora with other donors and organizations like SADC to facilitate communication and information exchange.

Illustrative Indicators

- Number of technical assistance/mission support visits
- Data available for all RHAP countries, analyzed from a regional perspective and disseminated for use in policy dialogue and programming
- Number of state of the art approaches disseminated

IR 3: INCREASED PARTICIPATION OF REGIONAL NETWORKS AND INSTITUTIONS IN COMBATING THE HIV/AIDS EPIDEMIC

Central to the long-term sustainability of USG assistance will be the capacity of local and regional institutions to respond to local need. There are currently a wide variety of regional networks and institutions in Southern Africa including regional donors (WHO, UNAIDS, World Bank), governmental organizations (SADC), private corporations (Coca-Cola, Shell, Exxon), non governmental organizations (NGO), community based organizations (CBO) and FBOs as well as training institutions that operate on a regional basis. All of these institutions currently have some capacity to contribute and collaborate in order to address the HIV/AIDS epidemic in the region. The Regional office can play a significant role in leveraging these resources to both address immediate needs across the region and contribute to long term sustainability. Apart from the obvious benefits, this will also help protect the substantial investments of the USG. It is important to note that support to this IR will only take place at higher resource levels. Potential areas of intervention and illustrative activities include:

- ***Support to regional policy development***

Given the massive roll out of treatment, the potentially explosive situation relative to orphans and a host of impending issues related to the HIV epidemic, a strengthened policy environment is imperative. Identifying appropriate regional policy making groups with which to interface will be an important step in moving this agenda forward. Policies are needed in virtually every area from drugs, to protocols, to standards of care for treatment, home-based care and orphan services. Likewise multilateral organizations like UNICEF, UNAIDS and WHO have the potential to play a stronger role in the policy arena. Even at current funding levels, CDC also plays an active part in this area – particularly with the multilaterals. CDC will increase assistance to this area given additional resources.

- ***Support regional institutions and networks in program implementation across the range of Emergency Plan priority areas***

Several important institutions and networks are already in place and working regionally, but need additional resources in order to scale up their activities. These include training institutions, which can train across the cadre of health care workers in ARV treatment, palliative care associations, and a satellite network capable of transmitting prevention, stigma reduction and treatment literacy information to either health care workers, clients or in-school youth. The private voluntary organization (PVO) and faith-based community is also poised for a region-wide response, with the lack of resources being their primary constraint.

- ***Support greater participation of the commercial sector in the response***

The corporate sector in Southern Africa has begun to recognize the implications of the epidemic on its bottom line. Many of these enterprises have regional reach. In addition there are organizations working on innovative approaches to dealing with the uninsured employed with regional implications. Again RHAP is ideally placed

to facilitate the scale-up of these approaches across the region. In addition there are a plethora of opportunities for Global Development Alliances (GDA) which the RHAP could facilitate across several countries in the region.

- ***Facilitate linkages with other sectors to strengthen HIV/AIDS interventions***

Across the region the need for a multi-sectoral approach, meaning linking HIV/AIDS prevention, treatment, and care interventions, where possible, to achieve economies of scale and maximum impact is important. The most obvious examples are in schools, the workplace and related to nutrition and food security. With sufficient resources RHAP is ideally placed to strengthen those linkages, both across USG groups, for example the Office of Food for Peace, Office of U.S. Foreign Disaster Assistance and the mitigation efforts taking place in USAID's Regional Center for Southern Africa, as well as with US and host country implementing partners. RHAP will facilitate those linkages through support to study tours, meetings, best practice identification and dissemination and application and, should funding be available, will support action research efforts in priority areas.

Illustrative Indicators

- Number of policies adopted by partner organizations
- Number of regional institutions supported by RHAP undertaking HIV/AIDS activities in at least two countries
- Number of regional commercial enterprises supported by RHAP undertaking HIV/AIDS activities in at least two countries

F. Critical assumptions

For the Regional program to be effectively implemented and to achieve significant results, the following assumptions are critical:

- Sufficient yearly funding to support and implement regional HIV/AIDS programs
- Other donors maintain or increase their level of funding in the region
- Effective communication channels between USAID/Washington, CDC/Atlanta, S/GAC, and the regional office
- Continued technical and program support from USAID/Washington (and other USG Agencies as needed)
- Continued support and buy-in from the bilateral programs in the Region
- Ability of the regional office to identify and contract qualified individuals to fill regional positions
- Adequate resources for, and good collaboration with the non-health sectors—especially agriculture and education
- No deterioration in the food security situation throughout the region
- No civil conflict or natural disaster in the region sufficient to disrupt major transport corridors

G. Surveillance, Surveys, Monitoring and Evaluation

Supporting consistent, comparable, and up-to-date data and promoting its dissemination and use in programming are at the heart of the RHAP strategy. As CDC has a strong comparative advantage in this area, all activities of this nature will be undertaken in a collaborative manner. RHAP will use Emergency Plan strategic information frameworks and indicators to monitor and report on progress in all service delivery areas. In addition, RHAP is committed to providing reporting information for all focus-country funded activities being implemented through the regional program in accordance with Emergency Plan timelines. A number of special studies or surveys may be required over the life of the strategy to address specific issues. These activities may include in-depth program evaluations, operations research on select technical topics, policy review and analysis, trend analyses, and others.

VI. RESOURCES AND MANAGEMENT PLAN

A. Expected Level of Program Funding for the Strategy

As final decisions regarding the use of Emergency Plan funds by the Regional offices are still pending, staffing and results have been projected at three funding levels: flat line/low, medium, or high level funding. This translates into the annual and five-year strategy period totals in the table below. It is important to note that the strategy has been designed to achieve the SO indicators at all funding levels. The difference will be in the magnitude of the results achieved, with the greatest achievement at the highest levels of funding and only very modest achievements at low levels. (The Illustrative PMP in Annex V, is based on low level funding for FY 2004 and medium level funding in the out years.) The amount noted in the flat line/low scenario is based on a straight lined budget from FY 2003, with a modest amount of "buy-in" from focus countries to support Corridors of Hope activities in their countries. At this level, there are some increases anticipated over the life of project for the focus country buy-in as their budgets are expected to increase significantly in the upcoming years. CDC is also straight lined at its FY 2003 levels and their out year funding expectations are still in negotiation. At this level IR 3 will not be funded.

The medium level assumes increased funding from USAID, with the majority of increased resources going to service delivery and some resources dedicated to IR 3. In addition funds are anticipated from S/GAC core which will be used to support technical assistance for S/GAC countries. CDC would also see modest increases at this level. The high level assumes increased funding from all sources.

B. Staffing levels

The expanded mandate, budget, and complexity of USG assistance to the region will necessitate an increase in staffing levels for RHAP. The new strategy calls for 4.5 professional staff, one administrative assistant and driver. The 50 percent position is the USAID funded portion of a monitoring & evaluation (M & E) advisor co-funded with CDC. In addition, RHAP serves as the base for a PMTCT expert who is funded from USAID/W with the specific charge to facilitate holistic approaches to programming in maternal and child health, addressing the interface of PMTCT programs, child survival and family planning and advance the state of the art. This staffing pattern is the minimum considered necessary to run the program. Hiring for these positions has already commenced and is expected to be completed by early FY2005.

Additional support will be provided by other USAID/South Africa offices including the Controller, the Regional Contracting Office, the Program and Project Development Office, and the Regional Legal Advisor. Should increased funding levels be achieved the mix of personnel would be adjusted. Skill sets for additional staff would be decided in collaboration with both country missions and CDC to assure synergy. Highest priority would be given to placing a U.S. Personal Service Contractor (USPSC) at the Embassies in Swaziland and Lesotho in order to oversee those programs and serve as the senior advisor on HIV/AIDS for the Embassies in those countries.

C. Implementation Mechanisms and Management

RHAP will use a varied, but limited, number of mechanisms to implement this new strategy. At lower resource levels, RHAP will primarily use the USAID field support mechanism. The one exception is in the cross-border activities where a cooperative agreement is planned. This will reduce the management burden associated with coordinating a number of Cooperating Agencies (CAs) working across several countries and will facilitate unified approaches and messages. This Agreement will be designed to allow bilateral "buy-ins". Should increased funding be available, the array of USAID implementing mechanisms, field support, Indefinite Quantity Contracts (IQCs), direct contracts, cooperative agreements or grants will be considered as appropriate. As implementation moves forward it will be important for the contractors and cooperating agencies to have a presence in the region—preferably in Pretoria to facilitate regular interface and enhanced collaboration.

Staffing will be undertaken using the Population Leadership Program (PLP), USPSCs, and, should a position become available, the Technical Advisor for AIDS and Child Survival (TAACS) mechanism. In addition, a new cooperative agreement will be considered to respond to demands for TA from Missions. Annual work-planning will be undertaken in collaboration with CDC to assure cohesive USG programming.

D. OE levels

No increase in OE beyond inflationary adjustments on current levels is anticipated. The current staffing level for the Regional program includes 1 OE position, the RHAP Office Chief. Should program funding levels increase, then some consideration to a second USDH can be given.

E. Results with Higher and Lower Level Support

At the straight line levels the emphasis is on modestly increasing support to Swaziland and Lesotho. COH would be maintained at current levels (assuming some focus country mission buy-in) and some limited TA and support to missions would be provided. At this level there will be no funding available to support IR 3 working with regional institutions to increase their participation, capacity and contribution to program sustainability. In fact, at

this funding level, support to Swaziland and Lesotho are also far below what is needed in order for them to begin to address the epidemic at the level of their neighboring countries and there is no expansion of other Corridors of Hope programs. This means, for example, that Angola's urgent request and compelling need for cross-border programs to address the movement of the epidemic across the Namibia border will not be addressed. In addition, at this level, any Emergency Plan country whose FY 2004 funding levels did not permit funding for COH cross-border sites, will see their programs closed.

At the medium levels, the regional program will provide a significant contribution to Missions in terms of TA and other support, and the learning agenda across the region will be significant. A major focus will be strengthening the response in Swaziland and Lesotho. Although funding will still be somewhat constrained, the medium scenario presents budget levels which will allow for a more strategic approach to the epidemic in these countries. In addition, at this level there will be some expansion of Corridors of Hope to include Angola and more resources available to address critical issues among other high risk border populations, for example targeting youth with abstinence programs. Importantly, at this funding level resources will be directed to IR 3 with activities working to leverage the participation and strengthen the capacity of regional organizations.

At the high level Lesotho and Swaziland will have comprehensive HIV/AIDS programs supported by in-country USPSCs. Corridors of Hope cross border activities will increase modestly. At this level, however, there will be significant inputs into strengthening regional networks and institutions. A priority focus at the high funding scenario is to build public-private partnerships with regional actors, with the aim of leveraging substantial amounts of resources to be used to combat HIV/AIDS in the region.

ANNEXES

ANNEX 1: Country Designations

| | USAID presence | CDC presence | USAID classification ¹ | CDC classification | Emergency Plan |
|---------------------|----------------|--------------|-----------------------------------|--------------------|----------------|
| Angola | v | v | Basic | Bilateral | |
| Botswana | | v | | Bilateral | v |
| Lesotho | | | | Regional | |
| Malawi | v | v | Intensive focus | Bilateral | |
| Mozambique | v | v | Intensive focus | Bilateral | v |
| Namibia | v | v | Basic | Bilateral | v |
| South Africa | v | v | Intensive focus | Bilateral | v |
| Swaziland | | | | Regional | |
| Zambia | v | v | Rapid scale-up | Bilateral | v |
| Zimbabwe | v | v | Intensive focus | Bilateral | |

¹ These country classifications have been lost for all operational purposes since the onset of the President's Emergency Plan. They are noted here as they were in place when the decision was made in Washington to strengthen regional HIV/AIDS programs

unless otherwise noted, statistics are from UNAIDS country-specific HIV/AIDS estimates and data, end 2001 (other dates noted in parentheses)--when high and low estimates are available, medians are noted here

* 2003 MoHCW (Zimbabwe), CDC-Zimbabwe, Futures Group, University of Zimbabwe, Biomedical research training institute/Imperial College of London, WHO, UNAIDS

" 2002 Sentinal/2002 DHS as noted in UNAIDS national response brief

~ 2002 Antenatal Attendees as noted in UNAIDS national response brief

^ 2002 estimate by FHI

` Measure DHS+ 2001/2002

**Nelson Mandela/HRSC Study of HIV/AIDS, national HH survey 2002

^^UNAIDS Report on Global HIV/AIDS Epidemic, 2002--high and low estimates available, medians noted here

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©MoH&P HIV Sentinel Surveillance Report 2003

=National AIDS Coordinating Agency, UNGASS Declaration Report, March 2003 & Botswana 2002 Second Generation HIV/AIDS Surveillance, Nov 2002 (new AIDS cases cumulative 2000-2002)

°Staneki projections (2001)

°°in-school/out-of-school (2002 BSS)

8Mozambique MoH sentinel surveillance, 2002

˘PSI KAP 2001 & 2003

Annex IV. Donor Matrix

| Regional Donor in HIV/AIDS | Countries to Which They Provide Assistance | Major Areas of Assistance | Funding Levels |
|-----------------------------------|---|---|--|
| AUSAID | 10 countries including South Africa | HIV/AIDS, TB, malaria and other communicable diseases; multi-sectoral focus; partnerships with African counterpart organizations (e.g., (APAC) | \$37,000,000 (2003-2008) |
| Belgium | SADC countries | HIV care and support; needs assessment; monitoring | \$401,000 (2003-2004) |
| CDC | Angola, Malawi, Zimbabwe, South Africa, Namibia, Botswana, Mozambique, Zambia, Swaziland, Lesotho | Support to regional missions (through cooperative agreement); VCT, public-private/workplace; surveillance; lab support; informatics, training and M&E | \$2,800,000 (Sept 2003 – June 2005) |
| Clinton Foundation | Mozambique, South Africa | Care and support (facility upgrading, training, ICT, etc.) | N/A |
| DANIDA (Denmark) | SADC | Poverty and HIV/AIDS (training, leadership) | \$10,900,000 (2001-2006) |
| DFID | Botswana, Lesotho, Namibia, Swaziland | STD and HIV/AIDS (High risk pop, youth, advocacy, service delivery, PLWA) | \$13,500,000 (2003-2007) |
| European Union | SADC countries | HCW training; care and support; multi-sectoral focus; NGO partnerships | \$49,200,000 (2001-2007) |
| Finland | Lesotho | Food security; care and support | \$8,500 (2003-2004) |
| Gates Foundation | No defined regional program | Research and NGO support | N/A (\$639 million worldwide for HIV and TB in 2003) |
| GTZ/Germany | N/A | Cross cutting funds; partnerships with government and NGO agencies | \$1,200,000 (2002-2005) |
| Ireland - Development Cooperation | N/A | Youth outreach; palliative care; based within academic institution; local/international networking | \$1,200,000 (2001-2005) |
| | | | |

| | | | |
|--|---|---|--------------------------|
| Japan (Japan International Cooperation Agency) | Mozambique, Swaziland, South Africa, Botswana, Lesotho, Namibia | Survey/research | \$5,000 (2003) |
| New Zealand Aid | SADC countries (to start in South Africa) | Education; HB care; awareness; and support to OVCs; CBO/NGO partnerships | \$291,000 (2003-2005) |
| UNAIDS | N/A | Donor coordination; PMTCT | N/A |
| UNDP | SADC countries | Workplace response; Mainstreaming HIV/AIDS into civil society; NGO/CBO and local government partnerships | \$2,000,000 (2001-2005) |
| UNICEF | Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia | Nutrition (linked with food security); OVC health | N/A |
| USAID | Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zimbabwe | Cross border prevention; VCT in high risk groups; peer education; BCC; STI treatment; PMTCT; FBO/CBO partnerships | \$14,167,032 (2000-2004) |
| WHO | N/A | Surveillance; TB; training | N/A |
| World Bank-Development Marketplace | Botswana, Lesotho, Namibia, South Africa, Swaziland | Capacity building; Income generation for PLWA; prevention/awareness (youth); OVC; stigma; workplace and private sector programs | \$370,000 (2003) |
| GRAND TOTAL (ESTIMATED) | | | \$133,000,000 |

Note: Foreign exchange conversions based on March 2004 rate.

SADC countries include: Angola, Botswana, Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe

ANNEX V. ILLUSTRATIVE PERFORMANCE MONITORING PLAN/SO LEVEL

| INDICATOR | BASE FY03 | FY04² | FY05 | FY06 | FY07 | FY08 |
|---|----------------------|-------------------------|--------------|--------------|--------------|--------------|
| Number of people ³ receiving counseling & testing for HIV/AIDS | 0 | 3.000 | 5.000 | 7.000 | 9.000 | 11..000 |
| Proportion of men reporting sex with a sex worker in the last 12 months | 0 | 10% decrease | 20% decrease | 30% decrease | 40% decrease | 50% decrease |
| Client countries satisfied with RHAP assistance | 0 | 6 | 7 | 8 | 9 | 10 |

² FY 2004 results assume low funding scenario. FY 2005 & beyond assume medium funding scenario.

³ Targets reflect illustrative trends and will be finalized as baselines are determined and as part of the Performance Monitoring Plan process.

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